FORM K
CLINIC SITE READINESS - INSTRUCTIONS

1. Complete the Clinic Site Readiness Form per instructions below.
2. Complete one form for every clinic site that will provide HTW support services funded through this RFP.

CLINIC SITE READINESS INFORMATION:	
Appropriate signage to identify funded entity.	Check that clinic sites have signage that identifies services provided at each site (Yes/No).
Space for clinical and administrative staff.	Check that clinic sites have adequate space to house clinical and administrative staff needed to run the clinics (Yes/No).
Locked storage for charts, records, medications and medical supplies	Check if there is locked storage at the clinic sites (Yes/No).
Proper Disposal for Medical Waste	Check if clinics have proper disposal for medical waste (Yes/No).
CLIA certification for level of tests performed.	Check if clinics have CLIA certification for the level of tests performed (Yes/No).
Handicap-accessible clinic sites that are geographically close to target population.	Check if clinic sites are accessible for persons with disabilities, and are located close to target population (Yes/No).
Appropriate facility(ies) where services can be delivered with clean exam rooms, space for client intake, and a place for clients to wait.	Check if respondent operates facilities with clean exam rooms, space for client intake and client waiting area (Yes/No).
Appropriate emergency policies/procedures and supplies as applicable?	Check if clinic sites have appropriate emergency policies/procedures and supplies necessary to provide services to the extent applicable for the setting and training, experience and competence of clinic staff. (Yes/No).
Appropriate use of interpreter and language translation services (including resources for both).	Check if there are resources for interpreter and language translation services, and if services are used appropriately (Yes/No).
Compliance with ADA requirements	Check if clinic sites are ADA compliant (Yes/No).
Financial management systems including secure data storage	Check if clinic sites have financial management systems including secure data storage. (Yes/No).

FORM K: HEALTHY TEXAS WOMEN CLINIC SITE READINESS

Legal Business Name of Respondent: _____

Clinic Site # of ____

Appropriate signage to identify funded entity?	☐ **Yes**	☐ **No**
Space for clinical and administrative staff?	☐ **Yes**	☐ **No**
Locked storage for charts, records, medications and medical supplies?	☐ **Yes**	☐ **No**
Proper disposal for medical waste?	☐ **Yes**	☐ **No**
CLIA certification for level of tests performed?	☐ **Yes**	☐ **No**
Handicap-accessible clinic sites that are geographically close to target population?	☐ **Yes**	☐ **No**
Appropriate facility(ies) where services can be delivered with clean exam rooms, space for client intake, and a place for clients to wait?	☐ **Yes**	☐ **No**
Appropriate emergency policies/procedures and supplies as applicable?	☐ **Yes**	☐ **No**
Appropriate use of interpreter services and language translation (including resources for both)?	☐ **Yes**	☐ **No**
Compliance with ADA requirements?	☐ **Yes**	☐ **No**
Financial management systems including secure data storage?	☐ **Yes**	☐ **No**

FORM K-1: HEALTHY TEXAS WOMEN CLINIC SITES INSTRUCTIONS

Complete a separate clinic form for each clinic site that will provide HTW services funded through this RFP.

Each clinic form must contain current and accurate information.

HEADER INFORMATION:	
Legal Name of Respondent	Respondent's legal name.
Clinic Site # ___ of ___	Example: Clinic Site #1 of 5 for the first clinic site out of five clinic sites, Clinic Site #2 of 5 for the second clinic site of five, etc.
CLINIC SITE INFORMATION:	
Clinic Name	State the name of the clinic.
Street Address	Physical address of clinic. (Do Not Enter a P.O. Box)
Suite	Indicate clinic suite number, if applicable.
City/County/Zip Code	City, county and zip code of clinic.
HSR	Health Service Region where clinic is located.
Clinic APPOINTMENT Phone #	Phone number to make an appointment at clinic.
Clinic PRIMARY Phone #	Primary phone number for the clinic site.
Fax	Fax number for the clinic.
Service Area	List counties served by the identified clinic site, NOT all counties served by the whole project. For a county to be considered part of a clinic's designated service area: (1) There must be a clinic located in the county; or (2) Five percent of the clinic population served in the previous 12 month period must have resided in the county. NOTE: Total counties served by all clinics must match the counties marked by respondent on Form B: Texas Counties and Regions.
Contact Person	Name of contact person for that clinic site.
Pharmacy License #	Current pharmacy license number for the clinic.
Class	Indicate class of pharmacy license (e.g., class D, A, etc.)
TPI#	Texas Provider Identifier # for the clinic, or date application submitted. Enter the TPI# that the clinic will use to bill TMHP for HTW services. The TPI# for each clinic site must be unique.
NPI#	National Provider Identifier # for the clinic, or date application submitted.
Subcontractor Site	Indicate whether or not the clinic site is a subcontractor site.
Mobile Site	Indicate whether or not the clinic site is a mobile site.
CLINIC HOURS AND SERVICES:	
Hours of Operation	List the operating hours of the clinic site for each day of the week by morning (e.g., 8am – 12pm), afternoon (12pm – 5pm), and evening hours (after 5pm). Indicate days of the week when the clinic is closed (e.g., Tuesday – closed).
Total Hours/Month	List the total number of hours of operation per month for the clinic site.

FORM K-1: HEALTHY TEXAS WOMEN CLINIC SITES

Legal Business Name of Respondent: _____

Clinic Site # of ____

CLINIC SITE INFORMATION: Complete this form for EACH clinic site that will provide HTW services funded under this RFP.

All information must be accurate.*

Clinic Name:			
Street Address:			Suite:
City:	County:	Zip Code:	HSR:
Clinic APPOINTMENT Phone #:			
Clinic PRIMARY Phone #:		Fax:	
Service Area *(counties to be served):*			
Contact Person:			
Pharmacy License #:	Class:		
TPI#:	NPI#:		
Submission date of Medicaid Application:			
Subcontractor Site: ☐ Yes ☐ No			
Mobile Site: ☐ Yes ☐ No			

CLINIC HOURS

DAY	HOURS OF OPERATION					
	Morning		Afternoon		Evening (after 5pm)	
	From	To	From	To	From	To
MONDAY						
TUESDAY						
WEDNESDAY						
THURSDAY						
FRIDAY						
SATURDAY						
SUNDAY						
TOTAL HRS/MONTH						